HealthComp
Third Party Administrators

FLEXIBLE BENEFITS PLAN CLAIM FORM

INSTRUCTIONS: Complete the appropriate spaces on this form and attach applicable Explanation of Benefits or receipts reflecting date of service, type of service and provider's ID number. Forward to: HEALTHCOMP, INC., P. O. BOX 45018, FRESNO, CA 93718-5018 (800) 442-7247 Fax (559) 499-2045

EMPLOYER: _____ **TELEPHONE** _____

EMPLOYEE NAME: _____ **SOCIAL SECURITY #** _____

ADDRESS : _____

☐ Check if address is different from last claim submitted

TYPE OF EXPENSE(S)	**AMOUNT REQUESTED FOR REIMBURSMENT**
☐ **Medical** ☐ **Dental** ☐ **Vision** ☐ **Other**	**$** _____
☐ **Dependent Care (*Please have provider complete bottom portion if no receipt attached)***	**$** _____

Reminder: **Cancelled checks or balance due statements are not acceptable bills and, when applicable, attach a copy of your Explanation or Summary of Benefits from your Insurance Company.**

To the best of my knowledge, my statements in this claim form are complete and true. I am claiming reimbursement only for eligible dependent care expenses and/or unreimbursed medical/dental/vision expenses incurred during the applicable plan year. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction.

_____ _____

Employee's Signature Date

FOR DEPENDENT CARE PROVIDER IF NO RECEIPT IS ATTACHED

Dates of Service _____ **Provider's ID#** _____

I verify that child care/elder care services were provided for the amount and dates indicated above.

_____

Provider's Signature

FOR OFFICE USE ONLY

CLAIM #	
PROC DT	
PAYMENT AMT.	
PAGE OF	**INIT.**